



MEDICATION RECORD

TO BE COMPLETED IN INK ONLY

** This form is to be used whenever a child receives medication or herbal remedies prior to care, or if needed during care. You must ensure that a copy of this form is given to the FDH Coordinator promptly after filled out by parent/guardian. All medication must be returned to parent after authorized period has ended and used according to the label.*

Child's Name: _____

Medication: _____

Medication amount & how to administer (if provider is to administer): _____

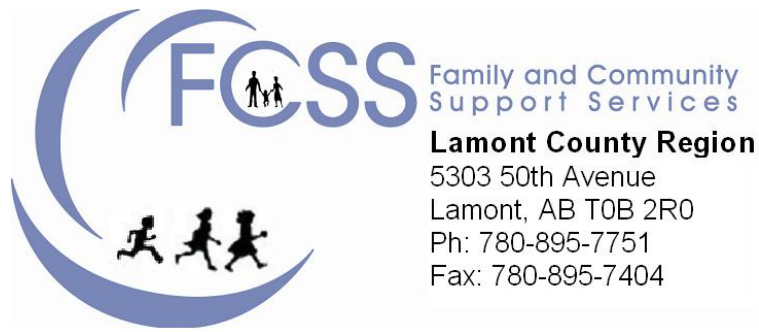
Parent Signature: _____

EVERY day your child receives medication prior to care, please update this form with the date, time, and your initials. : (i.e. Feb. 10/11 7:10 am P.R., Feb. 11/11 6:30 am P.R.)

Below to be completed by the staff at the time medication is given

Notice to staff members: Always ensure to observe children carefully for allergic reactions after administering medication or herbal remedies.

DATE	TIME	MEDICATION/DOSAGE	Allergic Reaction Y/N	INITIAL



DATE	TIME	MEDICATION/DOSAGE	Allergic Reaction Y/N	INITIAL

